bateman
ORTHODONTICS

PATIENT HEALTH HISTORY

Please fill out this form and bring it with you to your next appointment. We look forward to meeting you.

PART I: PATIENT INFORMATION

First Name _____ Preferred Name _____ Middle _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____

Birth Date _____ Age _____ Hobbies/Interests _____

School/Grade _____ Dentist _____ Physician _____

Primary Person Responsible _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ Employer _____

Dental Insurance Company _____ Flexible Spending Account ☐ Yes ☐ No

Group # _____ Insurance ID # _____ S.S. # _____

Secondary Person Responsible _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ Employer _____

Dental Insurance Company _____ Flexible Spending Account ☐ Yes ☐ No

Group # _____ Insurance ID # _____ S.S. # _____

PART II: PATIENT DENTAL HISTORY

Do you have, or have you had, any of the following:

Missing, Extracted, or Extra Teeth	☐ Yes	☐ No	Grinding/Clenching Teeth	☐ Yes	☐ No
Trouble Chewing	☐ Yes	☐ No	Clicking, Popping, or Jaw Joint Pain/TMJ	☐ Yes	☐ No
Sensitive Teeth	☐ Yes	☐ No	Facial Injuries or Trauma	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Periodontal (Gum) Problems	☐ Yes	☐ No
Root Canals, Crowns, or Bridges	☐ Yes	☐ No	Under/Over Developed Jaws	☐ Yes	☐ No
Thumb/Finger Sucking	☐ Yes	☐ No	Frequent Cold Sores	☐ Yes	☐ No

If yes, please explain _____

Do you have a dental cleaning and exam every six months? ☐ Yes ☐ No Date of Last Exam _____

PART III: PATIENT MEDICAL HISTORY

Have you been treated by a physician for any condition in the last two years? _____

Do you now have any, or have you ever had any of the following?

HIV/AIDS	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Anemia, Blood/Bleeding Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Arthritis, Bone/Muscle Problems	☐ Yes	☐ No	Immune System Problems	☐ Yes	☐ No
Asthma or Breathing Difficulties	☐ Yes	☐ No	Operations	☐ Yes	☐ No
Birth Defects	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Circulation/Blood Pressure Problems	☐ Yes	☐ No	Stomach, Liver, or Kidney Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Substance Abuse Problem	☐ Yes	☐ No
Eating Disorders	☐ Yes	☐ No	Taking a Bisphosphonate Medication	☐ Yes	☐ No
Endocrine Problems	☐ Yes	☐ No	Tonsil or Adenoid Problems	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Headaches or Earaches	☐ Yes	☐ No	Tumors, Cysts, or Cancer	☐ Yes	☐ No

If yes, please explain _____

Please list any medications taken _____

Do you need to be pre-medicated with an antibiotic before an invasive dental procedure? _____

Do you regularly take Advil, Aleve, aspirin or other anti-inflammatory products? _____

Do you drink carbonated beverages (soda) on a daily basis? ☐ Yes ☐ No If yes, how many? _____

Are you a regular user of tobacco products such as cigarettes or smokeless tobacco, etc? ☐ Yes ☐ No

Female patients: To the best of your knowledge, are you pregnant? ☐ Yes ☐ No

Girls only: Has the patient started her monthly periods? ☐ Yes ☐ No If so, approximately when? _____

Please provide any additional information that may be helpful in the diagnosis and treatment of your condition.

_____

PART IV: OTHER INFORMATION

How did you hear about our office? _____

Why did you choose us? _____

Have you had any other orthodontic consultations or treatment? _____

Have any family members ever had orthodontic treatment? _____

Bateman Orthodontics has my permission to obtain diagnostic materials deemed necessary for orthodontic evaluation. I also authorize Bateman Orthodontics to provide other health care providers with information regarding my/my child's orthodontic care, if considered appropriate. I also understand it is my responsibility to keep Bateman Orthodontics informed of any change in medical or dental health status and that, when appropriate, a credit bureau report may be obtained.

_____ _____ _____ _____

Parent/Patient's Signature Date Signature of Orthodontist Date